

September 18, 2003

Re: MDR #: M2-03-1714-01
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ____ for an independent review. ____ has performed an independent review of the medical records to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is certified in Chiropractic Medicine.

Clinical History:

This female claimant was at work on ____ when she injured her low back. She initially began physical therapy for approximately three months. After changing treating doctors, she underwent several more months of physical therapy, one epidural steroid injection to the lumbar spine, and one MRI of her lumbar spine on 09/13/02. The MRI showed degenerative disc disease at L5-S1, with a posterior disc bulge of 2.0 mm with no noticeable impingement, other than the displacement of epidural fat.

Disputed Services:

Repeat lumbar MRI.

Decision:

The reviewer agrees with the insurance carrier and is of the opinion that a repeat lumbar MRI is not medically necessary in this case.

Rationale:

Though the patient does not seem to have improved significantly from her treatment and continues to exhibit symptomatology associated with her injury, a second MRI would not likely show anything that would benefit her for future treatment. The symptoms do not seem to be consistent with a herniated nucleus pulposus, and a secondary MRI would not change her treatment protocol.

I am the Secretary and General Counsel of ____ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ____ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on September 18, 2003.

Sincerely,